



October 30<sup>th</sup>, 2025

The Honorable Thomas J. Engels  
Administrator  
Health Resources and Services Administration (HRSA)  
U.S. Department of Health and Human Services  
5600 Fishers Lane  
Rockville, MD 20852

**Regarding Notice of Request for Comments on Draft Recommendations to Update the HRSA-Supported Women's Preventive Services Guidelines Relating to Screening for Cervical Cancer**

Dear Administrator Engels,

On behalf of the Alliance for Women's Health and Prevention (AWHP), we appreciate this opportunity to comment on the WPSI Draft Recommendations for Cervical Cancer Screening. AWHP is focused exclusively on women's preventive health across all life stages and irrespective of any one disease area. We work in partnership with a diverse ensemble of leading women's health-focused organizations to advocate for equitable, accessible, and affordable preventive care. Success in our mission depends, in part, on preventive care recommendations that drive equitable access for all women.

We believe that cervical cancer screening recommendations must continue to support proven, comprehensive screening methods and allow for shared decision-making between women and their physicians. The recommendations must also account for ongoing inequities in awareness and access, not only across race and ethnicity but across other populations, as well, including women of varying socioeconomic circumstances.

Cervical cancer is preventable through regular screening and treatable with early detection. Since the introduction of Pap testing in the United States over 80 years ago, rates of cervical cancer have fallen by more than 70 percent.<sup>1</sup> However, recent studies show that cervical cancer incidence is no longer declining.<sup>2</sup> Additionally, many low-income, under-resourced women are not regularly screened or treated for cervical cancer, which contributes to higher rates of disease and death for these groups.<sup>3</sup> There is also evidence to suggest that women believe they will experience financial barriers to screening, particularly related to appointment costs and potential follow-up or future treatment costs.<sup>4</sup> This makes it all the more important that **final recommendations allow women to continue accessing all current, effective cervical cancer screening strategies, including Pap testing and co-testing with Pap + HPV together.** We have made significant progress in preventing unnecessary cervical disease, so now is the time to renew our commitment to the strategies that have contributed to our success.

We would like to propose two adjustments to incorporate in the final recommendations: **First, we encourage WPSI to provide equal access to all proven cervical cancer screening options, including co-testing (Pap + HPV), Pap testing alone, and clinician-collected HPV testing, for women ages 30 to 65.** Each method offers reliable protection based on current research. HPV primary testing should not be positioned as a preferred method over the others. **Second, we believe the final guidelines should clearly define the right patient population for HPV self-collection.** While AWHP recognizes the value of self-collection in certain populations, there is not strong enough data to ensure with high certainty that HPV self-collection provides substantial benefit. While HPV self-collection may be used to reach select underscreened women in the future, it is important to preserve the patient-physician relationship and proven standard of clinician-collected screening.

AWHP's women's [preventive health survey](#) underscores how insurance coverage and out-of-pocket costs are critical to how and when women receive preventive care. The survey highlights the existing disparities in cervical cancer screenings and shows that an overwhelming majority of women want insurance coverage to prioritize affordability, early detection, patient-provider decision-making and health equity impacts.

We remain committed to working with WPSI to address underscreening, health disparities, and gaps in care. Thank you again for allowing us to help inform this process. Please let us know if we can be of any assistance to WPSI as you consider our recommendations.

Sincerely,

**The Alliance for Women's Health and Prevention (AWHP)**

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1. Safaeian M, Solomon D, Castle PE. Cervical cancer prevention--cervical screening: science in evolution. *Obstet Gynecol Clin North Am.* 2007 Dec;34(4):739-60, ix. doi: 10.1016/j.ogc.2007.09.004. PMID: 18061867; PMCID: PMC2762353.

2. Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER Research Data, 8 Registries, Nov 2021 Sub (1975-2019). Published April 2024.  
<https://seer.cancer.gov/statfacts/html/cervix.html>

3. Suk R, Hong YR, Rajan SS, et al. Assessment of US Preventive Services Task Force Guideline-Concordant Cervical Cancer Screening Rates and Reasons for Underscreening by Age, Race and Ethnicity, Sexual Orientation, Rurality, and Insurance, 2005 to 2019. *JAMA Netw Open.* 2022 Jan 4;5(1):e2143582.

4. Perceived Financial Barriers to Cervical Cancer Screening and Associated Cost Burden Among Low-Income, Under-Screened Women. Caitlin B. Biddell, Lisa P. Spees, Jennifer S. Smith, Noel T. Brewer, Andrea C. Des Marais, Busola O. Sanusi, Michael G. Hudgens, Lynn Barclay, Sarah Jackson, Erin E. Kent, and Stephanie B. Wheeler *Journal of Women's Health* 2021 30:9, 1243-1252

